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A clear case for *conscience* in healthcare practice.

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Abstract

The value of conscience in healthcare ethics is widely debated. While some sources present it as an unquestionably positive attribute, others question both the veracity of its decisions and the effect of conscientious objection on patient access to healthcare. This paper argues that the right to conscientiously object should be broadened, subject to certain preconditions, as there are many benefits to healthcare practice in the development of the consciences of practitioners. While effects such as the preservation of moral integrity are widely considered to benefit practitioners, this paper draws on the work of Hannah Arendt to offer several original arguments in defence of conscience that may more directly benefit patients, namely that a pang of conscience may be useful in rapidly unfolding situations where there is no time to satisfactorily reflect upon our activities and that, given the hierarchical nature of healthcare institutions, a right to defy authority on the basis of conscience may benefit junior staff who lack the institutional power to challenge the orders of superiors.

A clear case for conscience in healthcare practice.

As healthcare professionals, how should we consider the judgements of conscience? Its perceived irrationality, its quasi religious status and its potential for professional abuse have led to the idea of a professional heeding their conscience being a discreditable abuse of their position, like a politician who fiddles their expenses. In fact, rights to conscientious objection are limited; while the law recognises conscience inasmuch as it provides a right to conscientiously object to participation in termination of pregnancy and embryo research, in most other situations sustained objections have resulted in the dismissal of the practitioner concerned,[1, 2] and I suspect practitioners who have objections consequently tend to utilise other, more surreptitious, means to avoid participation. Conscience is thus both misconceived and invisible in healthcare but for a small and controversial area of the law and this bulwarks the impression that conscientious objection represents a straightforward dichotomy between patient choice or practitioner rights. While conscience has its defenders within the healthcare ethics

discourse, few of these bring us any closer to resolving this dichotomy in a satisfactory way. While not considering specific controversies, but rather focusing on the value of conscience per se, in this paper I attempt to improve this defence of conscience in two ways: By offering an analysis of the properties of conscience that seeks to break it down into its constituent parts, *consciousness* and *voice of conscience*, I seek to explore the workings of conscience and suggest it can be the partner of reason in the reflective process. Secondly, by drawing on the relatively novel theories of Hannah Arendt, I argue that there is an intrinsic value in the exercise of conscience by healthcare practitioners that can improve the quality and probity of practice and therefore have real benefits for both practitioners and their patients.

Is practitioner conscience desirable?

If, as a junior member of the multi-disciplinary team, my conscience tells me to refuse to obey an instruction, what should I do? Certainly in current circumstances my position would be both legally and institutionally untenable, as cases lie on record of nurses being successfully dismissed due to similar refusals^a. Yet I cannot be alone in agreeing with Johnstone's,[1] observation that the idea of a nursing workforce that operated without conscience would be troubling, and I suggest this observation applies just as equally to doctors and physiotherapists. As Arendt observed in her reflections on the totalitarian systems of the Nazi Germany and Stalinist Russia,[3], the idea of obedience in itself is a morally questionable activity for creatures of reason such as human beings. For these reasons I cannot help but feel conscience has an important part to play in the delivery of healthcare, and this paper is conceived as a defence of this value of conscience per se, rather than as a defence of conscientious objection in any specific situation. This is important because an overemphasis on specific instances can hamstring practical considerations of this value, and, while healthcare literature contains wide ranging views of conscience^b, a significant section of the medical ethics discourse downplays the role of

^a See for instance *Warthen's case* (where a nurse was dismissed for refusing further attempts to dialyse a terminally ill patient after previous attempts had resulted in severe complications) in Johnstone M, *Taking a stand: conscientious objection, clinical ethics committees and whistleblowing* In: *Bioethics – a nursing perspective*, 4th ed. London: Churchill-Livingstone, 2005: 325.

^b Although there is a notable difference in the polarity of nursing and medical views.

conscience as a moral arbiter, and in particular the issue of conscientious objection to abortion dominates. This domination is perhaps because UK law^c only allows overt expressions of conscience in the rights to object to participation in termination of pregnancy,[4] and embryo research,[5]. The law does not demand an explanation of the objection from the practitioner and in the USA similar rights have seriously impacted on patient access to treatment,[6]. This crisis has led to ethicists such as Savulescu,[7] taking positions inimical to conscientious objection in healthcare. The problem a right of conscientious objection creates for patients with a genuine need for services provides a compelling case for reform, which I shall examine in due course. However, a case for reform must logically be preceded by an exploration of the value of conscience in the workplace, as the devaluing of conscience by Savulescu,[7] and others,[8] has been on the basis of its disutility. I would like to argue that this disutility is an extrinsic feature of how we treat conscience rather than an intrinsic feature of conscience itself. In order to do this I shall introduce the novel theories of Arendt, who reconsidered conscience through the lens of an era of extremity – the dictatorships of Hitler and Stalin - for I suggest these theories show that conscience is an intrinsically valuable faculty that contains much to commend itself to practice in the unusual circumstances of healthcare.

Arendt and the intrinsic value of conscience

Although post-enlightenment philosophers spent much time considering the fallibility of conscience and its relationship to reason,[9, 10] – a relationship I shall discuss later – conscience has a more universal property that is independent from notions of its reliability; that of providing an internalised second opinion over our thoughts and actions that is less easily persuaded than the faculties of reason, and Hannah Arendt,[11] closely considered this independent property. In the aftermath of the Second World War, Arendt was struck that some individuals in Nazi Germany resisted the regime despite the overwhelming mass of the German population not just consenting, but in many cases actively abetting, actions that were a complete inversion of previously universal moral values. She noted these resisters did not stop to think what was reasonable, but instead

^c I only consider UK law in this paper; however, US law is similar in this respect. The detail of the law is fairly unimportant as my point is that the law unduly influences the view of conscience taken by medical ethics commentators.

had something like an emotional opposition – as Arendt suggests, they did not say “I won’t”, but instead: “I can’t”. To Arendt this suggested a rare value of conscience in a crisis when normal rules had broken down. But what relevance could these revelations have to contemporary healthcare practice? Nazism – abhorrent and unique - is so far removed from anything we encounter in our lives today that Arendt’s observations are perhaps of anthropological or historical interest, but arguably have nothing in common with healthcare practice – indeed, given the great gulf between medical activities that are, at their best, the embodiment of humanitarian values, and a horrifying historical episode that is, to many, the summit of inhumanity, it may seem offensive to draw comparisons. Yet if we strip away our familiarity with the history of Nazism, and with the particular and distressing nature of its mission, and consider that it was an environment where normal values were suspended, a world where hierarchy and obedience became second nature, Arendt’s ideas have much resonance within healthcare. This is because the activities that routinely take place in some of the arenas of healthcare – operating theatres and intensive care for instance – are far removed from the normal rules that govern the day to day conduct of society. Practitioners in these environments face hierarchical and institutional pressures to conform to unfamiliar rules of conduct. Indeed it is a measure of the novelty of these situations that such a large area of study governs the rights and wrongs of its dilemmas and while this bioethics epistemology has been incorporated into professional guidelines, these cover by no means all ethical dilemmas of practice. Commonly accepted practice may not always be sufficiently scrutinised – for example the routine ‘treating to die’ of infants with Down’s syndrome is a relatively recent phenomena,[12] – or locally misinterpreted – for instance the decision to cease feeding an elderly woman with dementia by a General Practitioner,[13]. In both these instances the impetus for reform has come from practitioners who have followed their consciences in pressing for change. Even in instances where firm advice is available, loyalty to colleagues and deference to power structures and hierarchy can compete with the advice of professional bodies, and there are strong pressures on juniors to conform to the viewpoint of their superiors. These examples suggest Arendt’s ideas have relevance to the delivery of excellent healthcare despite the apparent incongruity of their root. However the intrinsic value of conscience cannot be realised in the current

circumstances, as I suggest there is profound disutility in the way conscience is treated in healthcare at present. There is a lack of openness about those decisions of conscience that are legally permitted that is encouraged by the lack of probity such decisions face. In turn, where there is no legal protection of conscience, this culture of silence is bulwarked by a very real fear among practitioners that they will face serious reprisals if they act on their consciences; the few cases on record of healthcare professionals doing so have resulted in dismissal,[1, 2]. This creates a climate where surreptitious avoidance of situations can flourish, and such surreptitious avoidance is by its very nature highly resistant to challenge. While the response of some critics to symptoms of disutility such as lack of availability of healthcare to patients requesting termination of pregnancy in the United States is to suggest further curtailment of already limited rights to conscientious expression,[7] I suggest such measures would simply drive conscience further into the shadows. What is needed is a wholesale reform of the way we treat decisions of conscience, reform that increases both probity and practitioner freedom.

A case for reform – openness and probity

A wholesale reform of the conscientious objection in healthcare that increases the probity of decisions of conscience as well as the right of practitioners to express them would allow ill conceived objections to be challenged and areas of practice that escape outside scrutiny to be examined, with net benefits to practice and patient care. The current legal mechanisms fail to balance the benefits of allowing practitioners freedom of conscience with negative impact on patients, and it's most radical critics suggest a curtailment of existing rights to conscientious objection is the remedy,[7]. Is further restricting expressions of conscience an effective solution? I suggest practitioners will find ways to avoid situations they find uncomfortable or unconscionable – whether justifiably or not. Of course the very nature of surreptitious behaviour makes empirical data hard to come by, however anecdotal accounts of strategies of patient avoidance suggest their *de facto* existence in day to day practice. For instance, in a commentary about conscientious objection, Johnstone suggests:

nurses have been 'conscientiously objecting' to workplace practices for years... ..by sidestepping a particular patient assignment, swapping shifts, declining to work in a particular ward or area, or taking a 'sick day' off work..., [1].

Similarly Zuger's recollections of her internship in a municipal hospital at the beginning of the AIDS epidemic suggests the medics possess strategies for surreptitious avoidance of patients they find unpopular or morally challenging:

The AIDS patient who never quite gets visited on morning rounds "because there's nothing new to say," "because all the students upset him," "because the intern will come back and talk to him later" ...,[14]

While neither commentator gives us incontrovertible proof of surreptitious avoidance on the basis of conscience, both examples suggest there are ample means at the disposal of practitioners to do so (even if, as in Zuger's example, the avoidance is morally unjustifiable). If this is the case, further restrictions on the expression of conscience are unlikely to impact positively on the phenomena of patient abandonment, as they may be countered by surreptitious avoidance. While I cannot comprehend a way a determined or unscrupulous practitioner can be prevented from exercising such surreptitious means, I suggest such behaviour may be discouraged by creating an accountable framework in which conscientious objection can take place. Such a framework would employ a bipartite approach of increasing both the rights to exercise conscience and the probity of those decisions. By increasing the scope of legal and institutional rights to conscientious objection we help to bring such practices into the open, and so long as these rights are accompanied by increased openness among practitioners, decisions of conscience may be discussed, challenged and subjected to scrutiny.

Others have already put forward convincing arguments of this nature: Meyers and Woods [6] contrast the rigorous examination faced by those who conscientiously object to military service with the lack of probity faced by medical conscientious objectors, and suggest that such a system of examination within healthcare institutions would avoid vexatious use of conscientious objection. There is a secondary benefit to this suggestion

because examination boards that contain a broad variety of practitioners and lay persons also ensure that conscientious objectors will highlight the occasionally shadowy world of practice to outside challenge and scrutiny. In saying this I think particularly of notorious failures of medical ethics such as the Tuskegee syphilis study,[15] or the use of deep sleep therapy in Queensland,[16] in which professionals were trapped in a conspiracy of silence despite evidence of moral doubt among them. I do not claim to offer a programmatic strategy for convening such boards, although several bodies exist that may take on such work. Clinical ethics advisory committees are already skilled in offering ethical advice and have the broad base of lay and clinical opinion that would be necessary. Similarly, the elected representatives on a foundation trust's council of governors may provide a broadly based group to referee conscientious objections.

While a bipartite strategy of increased openness and increased probity does not solve the problems of patient abandonment, or prevent the frivolous use of conscientious objection to avoid morally difficult situations, formal external examination, in requiring practitioners to give an account of their actions, would prompt personal reflection on the ethical appropriateness of their activities and the impact of their objection upon other staff and patients that may be missing from private avoidance. Such reflection^d could be retrospectively facilitated along the lines of the mentored supervision that is an established part of the practice of Social Work, Psychoanalysis and many other disciplines,[17, 18] for which already interest within the clinical arena,[19]. Perhaps more importantly, by calibrating the response to these dilemmas to openness and probity, practitioners may engage their moral faculties and take ownership of their activities, rather than hide behind untenable objections. But bringing conscience out into the open presents us with a potential inconsistency. Conscience is a private and insular mechanism and we need to adequately explain the relationship between its internal dialogue and the external reflective process; specifically we must understand the division of conscience

^d The benefits of reflection on practice are taken as read: reflective practice is widely advocated as a technique of practice improvement in nursing and other helping professions, although relatively new to medicine (see for instance Bolton G. *Reflective Practice: Writing and Professional Development*. Paul Chapman Publishing Ltd, 2001). In particular, practitioner awareness of their actions and activities is a professional manifestation of the 'examined life' (which has advocates from Socrates to Nozick), and a way to analyse the successes and failures of our professional activities. Analysis of this paradigm is beyond the scope of this paper.

itself into both *consciousness* and a *voice of conscience*. In doing so I shall now contend that conscience is a unique faculty, quite separate from reason, that informs itself in a way that is responsive to the external reflective process.

Reflection and the informing of conscience

Conscience accommodates two differing, yet inter-related concepts - *voice of conscience* as a reflex, gut feeling that something is morally wrong and *consciousness* as reflective insight into the impact of our actions,[20, 21]. This owes a great debt to Christian doctrine^e and it is perhaps unsurprising that the concept of conscience has diminished with the rise of secular ethics. Yet attributing this duality to conscience is not inconsistent with secularism, for I suggest it is not only a valid empirical observation, but that it is the interaction between these two modes of conscience that allows it to both develop and assert itself, and in so doing to exist in parallel to other sources of thought such as reason. This is important because the relationship between reason and conscience is a complex one. While post-enlightenment philosophical tradition suggests conscience is the lesser faculty as it is fallible to tradition and superstition,[10, 22] philosophers from Aquinas onward have contended that reason is itself not infallible. A more helpful approach, suggested by Andrew and Lindsey,[10] is to view both faculties as valid and to welcome the dynamic tension that sometimes exists between them – indeed, as they point out, an implicit overlap exists between them if we accept that notions underlying reasonableness contain implicit appeals to intuitive recognition of a common morality. How might this approach allow conscience, an insular mechanism, to be informed by the external reflective process I have described?

My suggestion is that voice of conscience - the reflex and instantaneous feeling of revulsion (or approbation) to a perceived moral wrong - is mediated by consciousness - the process by which we know our own thoughts and have something akin to a private dialogue with ourselves. Distress at one's actions has an effect on this dialogue, and it is

^e The source of this dual nature of *voice of conscience* / *consciousness* comes from early Christian philosophers, notably Saint Jerome, who, in a commentary on a biblical text, confused the Greek *syneidêsis*, (meaning “knowledge within”, to which the Latin *conscientia* literally corresponds) for the word *synderesis*^a (meaning “insight”) at a stroke lending a dual meaning to the Latin that does not exist in its ancient Greek equivalent.

consciousness where this moral distress manifests itself. This manifestation, because it is an introspective process, requires that we stop acting and review our activities retrospectively, a process that allows a dialogue with experience and reason. Conversely, the revulsion that manifests in voice of conscience is resolutely immune to reason. For consider that the *voice of conscience*, even when mastered by reason, still produces moral discomfort. This implies that voice of conscience is not in dialogue with reason any more than fear or love is governed by reason - it simply speaks too different a language. Nevertheless, voice of conscience is not frozen or incapable of influence or development, for it is through consciousness that it is in contact with our experiences and by conscious reflection on lived experiences that our voice of conscience is informed. The interface between consciousness and voice of conscience is thus apparent: Through consciousness we retrospectively consider our actions and their outcomes and through this consideration voice of conscience becomes accustomed to, or hardened against, them. Thus the duality of conscience has aspects that instantaneously judge and retrospectively review acts in a parallel process to reason, which explains the oddly human experience of our “head” telling us one thing while our “heart” tells us another. The upshot of this is that conscience cannot be informed by direct, contemporaneous appeals to reason, but instead by a process that is based upon reflection upon experience - a process that is necessarily retrospective. The external reflective process outlined in the previous section can thus provide the impetus and mental space for consciousness to stop and consider the experiences that drive the voice of conscience and provide an interface between the considerations of reason and conscience. Thus this division between “head” and “heart” is not an inconvenience we should aim to erase, but a dynamic process that we can aim to facilitate through a reflective process.

Conscience, then, contains both reflective and reflexive elements, that exist in dynamic parallel with reason. As a vital second opinion of our practice, conscience is too important a mental faculty for us to ignore when making moral decisions in healthcare and practitioners should be encouraged to listen to their consciences, rather than suppressing them. This is not to say we should follow our own internal compasses and live in a land of moral do-as-you-please. As I have explained, judgements of conscience must be open to challenge and explanation. Yet if I am correct and it is the reflective

process of *consciousness* by which reflexive judgements of *voice of conscience* are formed, it is reflection on our experiences, rather than appeals to reason, that will provide that challenge. But why is conscience so important? I now propose a number of instances where the properties of an active conscience identified in this paper can make unique contributions to meeting the multiple ethical and professional demands of the healthcare environment.

Conscience as an asset to good practice

Conscience is a place in practitioner's minds where they are shielded from the pressures of the healthcare environment and its relationships, obligations, ambitions and loyalties, all of which impact upon the decisions that they make while on duty. Because these pressures may result in the practitioner compromising their moral duties, it is essential the practitioner freely reflects on their actions from this standpoint. This process of (to turn a phrase) moral triangulation is essential if practitioners are to deliver their care to highest moral standards. This is not a revolutionary idea; the idea that conscious critical reflection upon our practice allows us improve and flourish as practitioners is common currency,[1, 23].

Acting against one's conscience is a discomforting experience; and some hold that it is a link to the core moral values that are an essential part of an individual's sense of self - so called *moral integrity*,[24]. Breaching these core values harms that sense of self, resulting in a loss of self-respect, feelings of discontent, and ultimately desensitisation of the conscience,[9, 22, 24]. This does not just harm the practitioner; the healthcare disciplines require intensive partnership between the professional and their patients, and persistently acting against one's conscience has been identified by practitioners as resulting in burnout and by researchers as resulting in desensitisation to patient suffering,[25]. These observations suggest there are strong pragmatic benefits to allowing the expression of conscience. While these concepts of moral integrity and reflective practice are relatively well explored in the literature, I suggest there are at least two more reasons we should defend decisions of conscience by healthcare professionals; both owe a debt to the philosophical insights of Arendt,[11].

Healthcare is a deeply hierarchical institution, and individuals, particularly those who are relatively junior in the hierarchy, may feel significant pressure to participate in activities they feel are morally repugnant. I claim a right to conscientiously object protects individuals from participation in immoral acts they lack the institutional power to effectively challenge. As Arendt noted, intuitive moral opposition may at times be more reliable than reason or mainstream values. I suggest this is because reason and logical argument can be internally correct, while ignoring the immorality of an activity.

Healthcare is an unusual environment and the morality of practice may not be easily discernable. Senior practitioners may dominate, and customary practice may become dangerously isolated from moral landmarks. Junior staff, being less accustomed and desensitised to the peculiarities of their environment, may have an outsider's insight into the ethics of practice that more senior and experienced practitioners have lost. It is therefore important to remove the hierarchical obstacles to making a moral objection.

The voice of conscience, as a reflexive judgement of the morality of a situation, may have special relevance in the healthcare environment, because in the sometimes fast paced decision making of healthcare, its ability to instantly grab the moral attention may give it an important advantage over more deliberative mechanisms. Emergency medical and intensive care environments are at the forefront of some of the most ethically contentious debates, and in these environments much can hang on decisions taken in response to rapidly unfolding events. Even where there are moments to briefly reflect, reason may offer only pragmatic responses to moral dilemmas^f. The ability to rapidly morally triangulate in such an environment is an important attribute of the voice of conscience.

Conscience is simply too important to ignore, and we should be no more dismissive of the challenge of conscience than any other mental faculty. It provides a mental space where practitioners can reflect upon their experiences and improve their practice; heeding conscience may allow them to remain sensitive to both their own and their patient's needs; conscience provides a voice to moral objection that is independent of dominant mores and hierarchy and an instant alarm when events begin to rapidly outpace the speed

^f For example, I think here of aggressive resuscitations, where patients have been "brought back to life" only to suffer days or weeks of futile and invasive treatment.

with which we can consider them. By fostering and respecting it, engaging with and interrogated its judgements, it will benefit practice and practitioners alike.

Conclusion

Conscience is intrinsically valuable, but this value is overshadowed by both a treatment in law that provides untrammelled rights of conscientious objection in a narrow range of circumstances and a disregard of its value in practice that has led to the dismissal of practitioners for acting upon it. Both circumstances conspire to produce a situation where decisions of conscience lack openness and probity. The issues of patient access to treatment are hugely important and the current unsatisfactory situation is in need of both legal and institutional reform if we are to see the best aspects of conscience flourish. By taking measures to increase the probity of decisions of conscience while simultaneously extending protection to all instances of exercise of conscience, we protect patients and practitioners alike, shining a light into areas of practice that are far removed from the normal rules of societal conduct and initiating a reflective process that exposes frivolous grounds for conscientious objection to comment and censure. There is much to commend conscience as a genuinely valuable faculty in clinical decision making. Conscience should complement reason and a dynamic interplay between these faculties should be welcomed. It is a complex faculty, with both reflective and reflexive elements that provide it with an ability to independently inform judgements and counterbalance both reason and institutional and hierarchical pressures – none of which are free from gravely erroneous conclusions on occasion. Conscience provides a platform for reflection that is free from the pressures that dominate the workplace, and an ability to follow their conscience may protect practitioners from disengagement with their practice and the patients in their care. Conscientious objection can empower juniors to challenge the failings of a hierarchy that can be otherwise inured to challenge. The voice of conscience can speak instantly in situations where there is little or no time to reflect. These are common situations in healthcare, and the unique contribution of conscience to their betterment must not be disregarded.

The healthcare environment is highly unusual both in the activities of its practitioners and the moral demands such activities place upon them. Practice requires huge levels of

intellectual and practical skill and human ingenuity, strong leadership and high levels of organisation. However, these skills must be balanced by openness and probity and an ability to apply moral behaviour in unfamiliar and difficult situations, sometimes in the face of considerable vested interests to the contrary, sometimes where there is simply no time to think. Promoting an active conscience in practitioners is a vital if we are to rise to these challenges.

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